TEMPLE UNIVERSITY HOSPITAL

Community Health Needs Implementation Strategy

FY17 Progress Report

TEMPLE HEALTH
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Community Health Needs Assessment

FY 17 Progress Report

In addition to addressing the areas of priority identified in the Temple University Hospital Community Health Needs Strategy, Temple University Hospital implemented a number of innovative programs to address community health. One of which we are particularly proud was our first Temple Health Fest, which we describe below. Two additional programs, which we include at the end of this report, are the Diabetes Prevention Program and our participation in the Collaborative Opportunities to Promote Community Health (COACH).

On Saturday, April 22, 2017 Temple University Hospital (TUH) held a Community Health Fest attended by approximately 1,300 community and staff members. TUH had heard feedback through the Community Health Needs Assessment that community members would like the opportunity for more face to face meetings with TUH staff and program leaders. Community members and leaders had an opportunity to visit and learn about strategies to promote health and wellness. The event helped achieve our purpose of giving the community an opportunity to meet with care providers in a relaxed environment, to help educate the community on health and wellness, and break down the community's reluctance to obtain primary and preventative care. Topics and offerings included: blood pressure and diabetes screenings, mental health assessments, tips for foot health, addiction resources, advice for sleep disorders, nutritionists, LGBTQ health, radiology education, cancer prevention and colon wellness, financial guidance, the OBGYN's Baby Box program, ambulance tours, fire prevention, food, face-painting and other family fun.

As part of the day's activities, in the Erny Auditorium adjacent to Health Fest, TUH honored Dr. Amy Goldberg, Scott Charles and the Cradle 2 Grave program they created for achieving a landmark of 10 years and serving more than 10,000 participants. The Erny Auditorium programs also featured physical and mental health panels and nutrition demonstrations throughout the day.

Women and Infants

Title: Reduce the incidence of infant mortality and improve access to better coordinate community resources for mothers and newborns.

Strategy Team Lead: Elizabeth Craig, CRNP, DNP, FACHE, Enrique Hernandez, MD, Chair, OB/GYN, Gail Herrine, MD

Goal: Improve the health of moms and newborns. Reduce the incidence of infant mortality and improve access to community resources for mothers and newborns. Continue the hospital and community partnership of a breast feeding resource center, as well as a community support group offered at Temple University Hospital and Episcopal Hospital. Improve the compliance with prenatal visits. Increase breast feeding initiation to a rate of 25%.

Summary of the Methods/Tactics Implemented: Strengthen and expand the role of obstetric and pediatric based community health worker programs within the Temple practices and surrounding community with a focus on womn at high risk for delivering a high risk infant. Implement strategies to enhance Safe Sleep in our newborns. Collaborate with community partners to improve access to Obstetrical Care, Prenatal & Lactation Education, healthy food and promote physical activity. Improve communication on the health status of pregnant mothers through collaborative practice arrangements. Reduce smoking and alcohol consumption through promoting smoking cessation and alcohol use awareness. Continue our support of the City of Philadelphia's MOM program, which connects mothers and their babies from birth through age 5 with social, educational, and healthcare supports. Some additional tactics: focused breast feeding education for attending obstetricians and resident physicians, actively engage in the Maternity Care Coalition Doula training program, monthly review of progress and outcome data at departmental meetings, establish a quality dashboard for regular reporting, utilize the Temple University Hospital Nursing newsletter to communicate progress, unit based staff meetings, community lactation meetings, and Quarterly Health Center updates.

Outcomes:

- Expanded our community health worker role within the Temple obstetrics practice focused on assisting women with high probability of delivering a high-risk infant and pediatrics
- Implemented a comprehensive plan for increasing breastfeeding and attaining Baby Friendly Designation under our Kellogg Foundation grant which is a comprehensive program inclusive of lactation, care coordination and post-discharge follow-up
- Implemented an Infant Safe Sleep Program including a research study, patient and family education, and a "Baby Box". Started a campaign to raise $30,000 to support safe sleep education and sponsor more baby boxes.
- As a key strategy in improving compliance with prenatal care, implemented a comprehensive coordinated approach to Prenatal Care & education CoFective Prenatal education materials in all prenatal practices and inpatient settings

- Collaborated with the team through our "EMPower Grant -Enhancing Maternity Practices -Breastfeeding" and Keystone 10 Initiative to support advancement of breast feeding education of patients, financial support for all phases of Baby Friendly Designation Application, and ongoing education of hospital personnel.
- Continued to expand our database to understand nutrition options in our community. Working with USDA Women, Infants & Children Food & Nutrition Program (WIC) and City Health Centers, Common Market, Farm-to families to improve access to nutritional foods and to educate families.
- Continued our smoking cessation awareness and education program. In partnership with City of Philadelphia, we are exploring a community resource access plan.
- Continued to strengthen our collaboration with the Maternity Care Coalition and Kellogg Foundation through their doula program.
- Continued our support of the City of Philadelphia MOM program, which connects mothers and babies from birth through age 5 with social, educational and healthcare support.

Conclusions/ Recommendations: The team continues to expand outreach and relationships in our community. This past year, the implementation of the Baby Box and associated research has expanded our relationships with various community partners including the Philadelphia Police Department and Philadelphia Fire Department.

Next Steps: These strategies will continue in the CHNA for Fiscal Year 2018. We have also developed a program called "Fourth Trimester" to extend relationships with families through the first year, our Baby Box initiative continues. Expansion of community partnerships is just an example of our goals

Obesity and Overweight

Title: Improve general knowledge of healthy food choices, and identify resources to aid in nutrition education.

Strategy Team Lead: Adam Messer, AHD and Elizabeth Craig, VP/CNO

Goal: Improve general knowledge of healthy food choices and identify resources to aid in nutrition education. Meet the goal of Healthy People 2020 to reduce adult obesity to 30.6%. Collaborate with community efforts focused on nutrition and weight management. Integrate nutrition education into all patient classes and group sessions (for example: preoperative joint replacement classes, transplant support groups). Include an educational program on nutrition and weight management as part of the patient education programming available through the internal TV programming at TUH. Collaborate with human resource programs at TUH to address employee obesity and provide nutritional education opportunities. Promote good cardiovascular health outcomes by addressing obesity and hyperlipidemia, major causes of cardiovascular morbidity and mortality.

Summary of Tactics Implemented and Outcomes:

- **Tactic:** Develop collaborative to assess and improve access to healthy food options for the community. Implement Food 'RX' to provide discounted or free food options for patients and community members with a validated clinical need or food security concern
- **Outcome:** Implemented Farm to Families Program at TUH in April 2017. Farm to Families provides boxes of fruits and vegetables on a weekly subscription basis at a discounted price. Since the implementation on April 27, 2017 we have sold 439 boxes, 191 to employees and 248 to community members. We plan to roll out a second phase which will improve education and awareness of the program to patients and community members through outpatient physician office visits, as well as through education to our allied health providers (dieticians, case management, social work, and nursing).
- **Tactic:** Perform a patient, employee, and community programs inventory to assess opportunities for collaboration and integration of CHNA program goals; leveraging both resources and access.
- **Outcome:** Completing program inventory through internal hospital efforts, population health management, TUHS benefits, and TU LKSOM programs.

Conclusions and Next Steps: Continue to sustain programs for healthy eating created in FY2016 and FY2017. Expand Farm to Families and Common Market programs through collaboration with TUHS and Lewis Katz School of Medicine; specifically the RX program. Collaborate with TUHS, TU, and community benefit programs to advance health food security in the region and educate community, staff, and patient populations regarding the health benefits derived by healthy eating.

Plan to Address Access to Mental Health Resources

Title: Plan to Improve Access to Mental Health Resources –Expansion and Coordination of Substance Abuse Services

Strategy Team Lead: Doris Quiles, MSN, APRN, BC Associate Hospital Director

Goal: Expand services within the Crisis Response Center and inpatient behavioral health service to provide care for an additional 3600 per year with substance abuse services

Summary of Tactics Implemented and Outcomes:

- **Tactic:** Submitted proposal to Community Behavioral Health for the expansion of the Crisis Response Center to accommodate an additional 4000 patients per year with substance abuse issues.
- **Outcome:** Community Behavioral Health did not provide approval for the program expansion until June, 2017. Now need to submit additional costs for the program to CBH.
- An additional 100 patients per month were served in the CRC starting in October of 2017 utilizing the same internal resources, average number of patients in the CRC each month is now is between 900-1000. Demographics of the population

  32% female; 68% Male
  47% African American, 23% Hispanic, 28% White, non-Hispanic
  8% born in 1950s, 22% born in 60's, 22% born in 70's, 31% born in 80's, 11% born in 90's

Primary Diagnoses

ETOH related – 10%
Opiate related – 22%
Cocaine related – 9%
Hallucinogen related – 5%
Schizophrenia forms – 9%
Unspecified Psychosis – 2%
Bipolar – 2%
Depression – 9%
Anxiety – 2%
Adjustment – 10%
Other – 20%
(Dementias, Marijuana, Schizoaffective, PTSD etc. – all less than 2% independently)

- **Tactic:** Developed a network of community providers who will provide a continuum of care for 3600 patients per year with substance abuse issues

- **Outcome:** Network of Community Providers developed and continues to be expanded. Working on project with the Department of Behavioral Health and Intellectual disabilities, and the Office of Addictions services to house recovery specialists in the CRC and ED to facilitate warm handoffs. Several providers have staffing coming to the inpatients units to facilitate discharge to the next level of care. Peer Specialist hired to work with patients to transition them to aftercare with substance abuse programs and with mental health programs. Peer specialist resigned in May. We are now looking to hire a BSW Social Worker to continue this work and provide linkage to the appropriate aftercare providers. A Senior Leader at Episcopal was appointed to the Mayors Opioid task force.
- TUH-E also joined the Temple Health System Substance Abuse taskforce which looks to expand services within the health system and work with community partners to facilitate linkage to the next level of care.

Conclusions and Next Steps:
Need to continue to expand substance abuse services and linkage to the next level of care. We continue to look at ways to expand services and are looking for funding to expand services on the campus with the addition of an inpatient detox/rehab unit. This requires capital investments for which outside support are required. We are engaging in a partnership with another agency to provide onsite Drug and Alcohol Outpatient and Intensive Outpatient services on campus, along with giving us access to a strong continuum of care including, outpatient substance abuse, recovery houses, long term residential treatment facilities, rehabilitation facilities, mobile outreach teams and case managers**.**

Plan to Reduce Gun Violence

Title: To strengthen awareness of gun violence

Strategy Team Leads: Scott Charles, Trauma Outreach Coordinator, Temple University Hospital Trauma Program and Amy Goldberg, M.D., Chair of Surgery Lewis Katz School of Medicine at Temple University and Chief of Surgery Temple University Hospital

Goal: Strengthen awareness of the dangers of gun violence to reduce hospitalizations, barriers to preventative health care, and to improve the quality of living in our underserved community

Summary of Tactics Implemented and Outcome:
Tactics for this fiscal year were designed to educate the Philadelphia community's youth about the dangers of gun violence (Cradle to Grave), how to provide first aid to gunshot victims (Fighting Chance), promote the use of gun locks (Safe Bet) and to seize a teachable moment with education and resources for victims of gun violence within the first 48 hours of hospitalization (Turning Point).

- Delivered our Cradle to Grave (C2G) program presentation to hundreds of Philadelphia residents, a significant number of whom were at-risk youth residing in North Philadelphia.
- C2G delivered a series of presentations modified for young offenders being detained at the Philadelphia Juvenile Justice Center. These presentations were given to individuals through the facilities school program.
- Continued Project Fighting Chance, which uses volunteers from TUH's Trauma and Emergency Medicine departments to train community members to administer first aid in the wake of a shooting. To date, the project has trained hundreds of residents living in neighborhoods suffering high rates of gun violence.
- Created a free gun lock initiative called Safe Bet, which aims to reduce occurrences of unintentional firearm injuries among children. To date, approximately 2,000 gun locks have been distributed through this effort. Working in collaboration with SEPTA Police, more than 400 gun locks were distributed during a single giveaway at the Broad and Erie subway stop in North Philadelphia.
- Continued the Turning Point program, which connects gunshot victims with personal and education counseling, employment placement, and housing assistance in an effort to reduce the chance of retaliation and re-injury.

Conclusion and Next Step: We conclude that the North Philadelphia community is receptive to efforts to educate the public about the effects of gun violence. These efforts will continue into the next fiscal year.

Plan to Strengthen Culturally Competent Care

To provide staff and physicians with education and resources to deliver culturally competent care.

Strategy Team Lead:
Sherry Mazer, Chief Regulatory Affairs Officer
Angel Pagan, Director of Linguistics and Cultural Services

Goal: To improve health care outcomes by educating care providers how to provide culturally competent care.

Summary of Tactics Implemented and Outcomes:

- **Tactic**: Promote awareness of health disparities through the annual Cultural Competence in Healthcare Symposium
- The presentations that have been presented included:
  - Keynote address on Culture, Context, and Health
  - Cultural Competency in Healthcare: Asians
  - Disparities in Latino American Patients
  - Cultural Competency & Implications for Quality Care for the Arab Community
  - Health Disparities,
  - Cultural Competency & Implications for Quality Care for the African American Community

- **Outcome**: The 5th annual Cultural Competence in Healthcare Symposium took place on April 22, 2017. There were over 130 Temple Health staff members and clinicians in attendance. The event provided information to participants on the importance of providing culturally competent care to our diverse patient populations.

- **Tactic**: Improve interpretive services

  - Add the following languages to the existing American Sign Language Video Remote Interpreter system:

    - Spanish
    - Arabic
    - Russian
    - Polish
    - Cantonese
    - Mandarin

- **Outcome**: After overcoming technical barriers, the addition of other languages to the current video conference system is set to be tested July 2017as a pilot at Temple University Hospital and eventually rolled out to all Temple Health facilities. The system is going to provide a live interpreter via video conferencing. This will facilitate communication

between our patients and clinicians. The languages selected are the highest volume languages for patients throughout Temple Health facilities.

- **Tactic**: Develop new Temple Health educational resources for culturally competent care.

    - Develop a series of educational webinars utilizing the recorded presentations from the 5th annual Cultural Competence in Healthcare Symposium to reach all Temple Health staff that was unable to attend the event.
    - Develop a mandatory competency for Cultural Awareness for all staff.
    - Provide resources for target ethnic groups.

- **Outcome**:
    - Online educational webinars: due to technical difficulties, this goal was not completed.

- **Mandatory Competency**: A mandatory competency for Cultural Awareness was developed and will be initiated in the FY 2018 competencies for all staff. Resources for target ethnic groups were provided at the Cultural Competency Symposium for the Arabic and Hispanic populations.

Conclusions: The promotion of cultural awareness is an important part of providing care to our diverse patient populations. It promotes respect to other cultures, increases patient trust, improves clinical outcomes, and it equalizes access to care.

Next steps:

- The name of annual Symposium will change from Cultural Competence to Cultural Awareness.
- The target population for the 6th Annual Symposium will be the LGBTQ population.
- The Temple Health LGBTQ Alliance will partner with the Symposium Committee.
- Fully implement webinars/ educational videos to provide continuous education to our staff on cultural awareness.
- Fully implement additional languages other than American Sign Language to the Video Remote Interpreter system.

    - Spanish
    - Arabic
    - Russian
    - Polish
    - Cantonese
    - Mandarin

Budget: $606,000.00 – Professional fees for interpretive services for FY18.

Plan to Address Diabetes

Title: Diabetes Prevention Program

Strategy Team Lead: Ronni Whyte, Director Population Health

Goal: Identify TUHS patients, employees and community members within the TUHS catchment area who are pre-diabetic. Engage them in the Diabetes Prevention Program using CDC curriculum and educate them to incorporate exercise into their daily routine along with calorie and fat control to attain a 5-7% weight loss and increase their activity level to 150 minutes per week or 2 ½ hrs.

Summary of Tactics Implemented and Outcomes:

- **Tactic:**
  - Temple Center for Population Health (TCPH) is participating in a CDC-funded grant with the Philadelphia Department of Health to provide free Diabetes Prevention Program classes at various locations in the TUHS catchment area and North Philadelphia.
  - TCHP was granted a third year of CDC grant funds in collaboration with the Philadelphia Department of Health. The core of the program is focused on training Community Health Workers (CHWs) to be lifestyle coaches for the purposes of managing pre-diabetes, hypertension and obesity. This year's funding is intended to expand hypertension education in the Temple Physicians' Incorporated (TPI) practices for newly diagnosed hypertensive individuals. The grant provides an additional $95,000 to expand education services in two additional practices, commencing in October 2018.

- **Outcome:**
  - Year 1 Diabetes Prevention Program (DPP) graduates updated surveys which were in process for status of lifestyle changes to be current post-graduation.
  - Year 2 of the Diabetes Prevention Program ended February 2017 with approximately 20 graduates.
  - Year 3 DPP sessions began October 2016 with about 70 attendees now in session that will end October 2017.
  - Three additional DPP sites were added in year 3 of the Grant totaling 6 sites. Year 4 of the DPP began in March 2017 with 2 additional sites supported by $145,000 of grant funding. Enrollment for year 4 will continue through February 2018.
  - Current Locations for DPP sessions include North Philadelphia: TUHS, Bright Hope Baptist Church, Zion Baptist Church, Mercy Neighborhood Ministries, Fortaleza Rehab & Fitness Center; N.E. Philadelphia: Jeanes Hospital & Klein Life Community Center; Center City: Law Enforcement Health Benefits (LEHB).

Conclusions and Next Steps:

- Grant year 4 will begin September 20, 2017
- Additional classes will be offered at various locations

Plan to Address Hunger and Food Insecurity

Title: Collaborative Opportunities to Advance Community Health (COACH)

Strategy Team Lead: Ronni Whyte, Director Population Health

Goal: Identify food insecurity in TUHS discharged patient population and connect them to appropriate food resources or the Philadelphia Department of Health which will assist with financial resources.

Summary of Tactics Implemented and Outcomes:

- **Tactic:** Philadelphia city-wide collaborative to identify and address poor health outcomes related to food insecurity. Food insecurity is defined as the lack of consistent access to affordable, nutritious food.

- **Outcome:** The Health System hospitals have joined the collaborative. Temple University Health System, Children's Hospital of Philadelphia, Einstein Healthcare Network, Holy Redeemer Health System, Jefferson Health (including Abington Jefferson Health and Aria Jefferson Health), Mercy Health System, and University of Pennsylvania Health System along with Benefits Data Trust, Drexel University's Center for Hunger-Free Communities, Coalition Against Hunger, Delaware Valley Regional Planning Commission, The Food Trust, Health Federation of Philadelphia, Health Partners Plans, Keystone First, Philabundance, Philadelphia Association of Community Development Corporations, SHARE Food program, and United Way of Greater Philadelphia and Southern New Jersey have begun a food access pilot designed to connect patients in need with appropriate resources and programs.

Conclusions and Next Steps:

- Attempts are made to contact all patients by telephone who are discharged from TUHS main hospital within 48 hours after discharge from an inpatient stay. A phone call is made by a Community Health Worker in our Access Call Center where questions are asked regarding discharge needs for medications, follow up appointments, and discharge instructions. A 2-question screening tool to identify food insecurity will be integrated into the existing call process to screen patients for food insecurity and when screened positive, food resources will be provided.

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